PEOPLE'S REPUBLIC OF HEALTH

INITIAL INTAKE HISTORY

TODAY'S DATE

Welcome to PRH! Please take a few minutes to fill out the following health history so that we may know how to better help you at your first visit. All of your information is absolutely confidential.

Name:	Dob:	Age:
Gender:	Occupation:	Employer:

When your health care practitioners work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?

Physician:	Physician's Phone#

Have you been treated with acupuncture or Chinese medicine before? If yes please tell us briefly about your experience.

Yes:	This is my first time! (circle one) excited – nervous – skeptical – thrilled

Please write in your TOP 3 health concerns in order of importance to you. Select the severity of the condition and indicate what makes it better or worse.

REASON FOR VISIT #1

Condition:	
When did this start:	Severity: (circle one) 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10

Let us know if you have noticed a difference with: (circle one)

HEAT	better	worse
COLD	better	worse
DAMP	better	worse
DRY	better	worse
ACTIVITY/EXCERICSE	better	worse

I WOULD ALSO LIKE TO WORK ON #2

Condition:	
When did this start?	Severity: (circle one) 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10

Let us know if you have noticed a difference with: (circle one)

HEAT	better	worse
COLD	better	worse
DAMP	better	worse
DRY	better	worse
ACTIVITY/EXCERICSE	better	worse

CAN ACUPUNCTURE HELP ME WITH #3

Condition:	
When did this start:	Severity: (circle one) 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10

Let us know if you have noticed a difference with: (circle one)

HEAT	better	worse
COLD	better	worse
DAMP	better	worse
DRY	better	worse
ACTIVITY/EXCERICSE	better	worse

HABITS Amount/Week - If Quit, what year?

Coffee ______________________________
Tea ______________________________
Tobacco ______________________________
Alcohol ______________________________
Drugs ______________________________

EXCERCISE

Do you exercise regularly?
If so, what and how often?

VITAMINS	MEDICATIONS

Check the 'YOU' column if you have/had the condition and note the year it started. Check the 'FAMILY' column if you have a blood relative with the condition.

	You	Family		You	Family
Cancer			Allergies		
Diabetes			Asthma		
Heart			Kidney		
Blood Pressure			Thyroid Disorder		
Pacemaker			Anemia		
Stroke			Hepatitis		
Seizures			Alcoholism		
Osteoporosis			Mental Hx		

SURGERY & HOSPITALIZATIONS

YEAR / REASON

Please use the other side if there is more you would like for us to know.

TEMPERATURE Do you run Hot or Cold?

Cold Hands/Feet	Thirst for Cold	Night Sweats	Hot Hands, Feet
Chills	Thirst for Hot	Unusual Sweats:	Hot Flashes
Cold in the Bones	Absence of Thirst	When & Where?	Hot in Afternoon
Numb Area's	Excessive Thirst		Hot at Night

MOISTURE How Dry/Oily is your overall body moisture (Hair, Skin, Mouth):

Dry Skin	Dry Lips	Dandruff	Oily Skin
Dry Hair	Dry Throat	Rashes:	Oily Hair
Dry Eyes	Dry Nose/Bleeds?	Where?	Dampness:
Dry or Brittle Nails	Edema/Swelling:	Itching:	Where?
Dry Mouth	Where?	Where?	Thirst?

DIGESTION Generally your digestion is: Great? Good? Fair? Poor? BM's/Day __________

BM's Keep Shape	Diarrhea/Constipation	Bad Breath	Difficult to Pass
Bloating	Belching	Heartburn	Tired after BM
Indigestion	Poor Appetite	Excess Hunger	Foul Smell
Gas	Nausea/Vomit	Dry Stool	Hemorrhaoids

ENERGY My General Energy is: Great? Good? Fair? Poor?

Sudden Drops in Energy	Body/Limbs Feel Heavy	Bleed/Bruise Easily
Energy Drops After Eating	Body/Limbs Feel Week	Hard to Concentrate
Fatigue	Shortness of Breath	Poor Memory
Caffeine Dependence	Heart Palpitations	Dizzy/Lightheaded
Wired & Tired	Not Grounded	Headaches x Week

SLEEP How many hours/night________ What time do you go to sleep____________

Difficult Falling Asleep	Restless Sleep	Not Rested Upon Waking
Wake at Night:	Disturbing Dreams	Sleep Is Not Deep
How Often/What Time?	Wake to Urinate	Sleep Too Much

EMOTIONS What Emotions Dominate Your Experience?

Anger	Worry	Joy	Timid/Shy
Irritable	Obsessive	Depression	Indecision
Stress	Grief	Sadness	Worthless
Anxiety	Frustration	Panic	Happiness

EAR, EYES, NOSE, THROAT

Allergies	Spots in Eyes	Poor Hearing	Sore Throat
Asthma/Wheezing	Poor Vision	Ringing in Ears	Dental Problem
Sinus Congestion	Itchy Red Eyes	Excess Ear Wax	Mouth Sores
Phlegm (Color?)	Night Blindness	Catch Colds Easy	Persistent Cough

URINARY Fluid Intake roughly ='s Urination?

Decrease in Flow	Blood in Urine	Sores on Genitals
Dribbling	Burning Sensation	Prostate Disorder
Pain on Urination	Cloudy Urine	Hernia
Urgency to Urinate	Discharge	Erectile Dysfunction
Frequent Urination	Change in Sex Drive?	Premature Ejaculation

We encourage you to consult your medical doctor for any health problems for which you are seeking treatment.

SIGNATURE	DATE

PEOPLE'S REPUBLIC OF HEALTH: WOMEN

MENSES

Day of Last Menstrual Period:	Do you track your cycle? Yes – No If yes, how?

Age at First Menses	Menstrual Flow: Heavy – Medium - Light
Length of Flow	PMS: None – Some – Too Much
Are you Pregnant	Cramps: Before? During? After?
How many Weeks	Fatigue: Before? During? After?
# of Pregnancies	Digestion/Hunger Changes
# of Abortions/Miscarriages	Mood Changes
Birth Control Pill?	Spotting
Irregular Periods	Clots
Yeast Infections	Painful Periods
Acne	Breast Tenderness

MENOPAUSE

Age at Last Menses	Night Sweats : ____ x day ____ x night	Hot Flashes: ____ x day ____ x night
Year Changes Began	Vaginal Dryness	Loss of Sex Drive